# RED WING SCHOOL DISTRICT #256
# AUTHORIZATION FOR GIVING MEDICATION IN SCHOOLS

**To be filled out by parent or guardian**

Name of Student _____ Grade _____

School _____

Parent/Guardian's Name _____

Name and Dosage of Medication _____
_____

Time to be given _____
_____

1. This medication can be given at school by designated personnel.

2. I understand that school personnel are not liable in the event any reaction results from the medication when properly administered.

Date: _____ _____
Signature of Parent or Guardian

**NOTE**: Medication must be supplied in the purchased bottle.

---

**To be completed by a physician for prescription medication**

1. Medication _____
   Dosage _____

2. Reasons why this medication must be administered during school hours
   _____
   _____

3. Any special side effects or precautions that need to be considered when administering this medication
   _____
   _____

4. Prescription valid until _____

Physician's Signature _____

Phone _____